

**Texas Department of Insurance, Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**PART I: GENERAL INFORMATION**

Requestor's Name and Address: 4600 TEXAS GROUP 2777 ALLEN PARKWAY STE 460 HOUSTON TX 77019	MFDR Tracking #: M4-09-3346-01
Respondent Name and Box #: OLD REPUBLIC INSURANCE CO Carrier Rep Box #: 42	

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

The Requestors' position summary taken from the subclaimant notice dated February 13, 2008: "...The Subclaimant, Unicare Life & Health Insurance Company, has a financial interest in this matter by virtue of payment of compensable medical costs, and is qualified under Sec.409.009(2) and Sec. 409.0091 because the Carrier has refused reimbursement of the compensable benefits after request...."

Principle Documentation:

1. DWC 060
2. Affidavit

Total Amount Sought \$2,420.37

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary dated, December 17, 2008, states in part, "... Because no final adjudication has been received as to whether the condition is or is not related to the compensable injury the Requestor's request for medical dispute resolution is premature."

Principle Documentation:

1. DWC 060 Response
2. PLN-11
3. TWCC-24

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Disputed Service(s)	Calculations	Amount in Dispute	Amount Due
Unspecified on the Table of Disputed Services	Unspecified on the Table of Disputed Services	N/A	\$2,420.37	\$0
Total Due:				\$0

PART V: FINDINGS AND DECISION

This Medical Fee Dispute is decided pursuant to Tex. Lab. Code Ann. § 413.031, and Tex. Lab. Code Ann. §§ 409.009, and 409.0091 of the Texas Workers' Compensation Act, and pursuant to all applicable, adopted Rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. Tex. Lab. Code Ann. § 409.0091 applies only to dates of injury on or after September 1, 2007 **except** as provided by Tex. Lab. Code Ann. § 409.0091(s).
2. The services in dispute relate to an injury that occurred on 12/19/03.
3. Tex. Lab. Code Ann. § 409.0091(s) applies for the date of injury 12/19/03.
4. Tex. Lab. Code Ann. § 409.0091(s) states that if information was provided to a health care insurer before January 1, 2007 under Tex. Lab. Code Ann. § 402.084(c-3), the health care insurer may file for reimbursement from the workers' compensation carrier not later than March 1, 2008; and may file a subclaim with the division if the request for reimbursement has been presented and denied not later than March 1, 2008.
5. Tex. Lab. Code Ann. § 409.0091(f) relates to the form and manner in which the health care insurer shall file for reimbursement from the workers' compensation insurance carrier.
6. The provisions of Tex. Lab. Code Ann. §§ 409.009, and 409.0091 apply to dispute resolution.
7. 28 Tex. Admin. Code §133.307 and 28 Tex. Admin. Code §140.8 set out the procedures for health care insurers to pursue medical fee dispute resolution.

Issues

In reference to the health care insurer's / subclaimant's request for medical fee dispute resolution, the division will address the following:

- Did the requestor file for dispute resolution in accordance with Tex. Lab. Code Ann. §§ 409.009, 409.0091?
- Is this request eligible for medical fee dispute resolution under 28 Tex. Admin. Code § 133.307 and 28 Tex. Admin. Code §140.8?

Findings

On August 4, 2010, MFDR requested additional information under 28 Tex. Admin. Code 133.307(e)(1) from the requestor in this dispute. MFDR requested a position statement for the purpose of establishing whether the request for dispute resolution was made under the authority of Tex. Lab Code § 409.009 or § 409.0091. The requestor did not provide the information requested, therefore the division will address the request for dispute resolution under both Tex. Lab Code §§ 409.009 and 409.0091.

1. Tex. Lab. Code Ann. § 409.009 states, "A person may file a written claim with the division as a subclaimant if the person has: 1) provided compensation, including health care provided by a health care insurer, directly or indirectly, to or for an employee or legal beneficiary; and 2) sought and been refused reimbursement from the insurance carrier." Because the requestor alleges to have been denied reimbursement, a dispute may be filed under the appropriate dispute resolution process. Similarly, Tex. Lab. Code Ann. § 409.0091 (l) requires that "Any dispute that arises from a failure to respond to or a reduction or denial of a request for reimbursement of services that form the basis of the subclaim must go through the appropriate dispute resolution process under this subtitle and division rules." 28 Tex. Admin. Code §133.305 delineates the appropriate processes for the dispute of medical bills.
2. The respondent filed a dispute to the medical fee dispute resolution section at the division. According to 28 Tex. Admin. Code §133.305(4), a medical fee dispute is a dispute that involves an amount of payment for non-network health care rendered to an injured employee (employee) for health care determined to be medically necessary and appropriate for treatment of that employee's compensable injury is resolved by the Division of Workers' Compensation pursuant to 28 Tex. Admin. Code §133.307. Similarly, 28 Tex. Admin. Code §140.8(h) states that "Disputes regarding extent of injury, liability, or medical necessity must be resolved prior to pursuing a medical fee dispute." 28 Tex. Admin. Code §133.307 (e)(3)(G) requires that if the request for fee dispute resolution contains an unresolved adverse determination of extent of injury, 28 Tex. Admin. Code §140.8 (h)(1)(A) goes on to state that the appropriate dispute process for unresolved issues of extent requires filing for a benefit review conference pursuant to § 141.1. The respondent's position summary indicates the dispute contains unresolved issues of extent of injury. The division notes that on April 28, 2009 the requestor was given written educational information related to the appropriate dispute process. The requestor provided no documentation to support that the issues of extent of injury were resolved as of the undersigned date. Therefore, the requestor has failed to support that the services are eligible for medical fee dispute resolution under 28 Tex. Admin. Code §133.307.

Conclusion

For the reasons stated, the division finds that the requestor has failed to establish that reimbursement in the amount of \$2,420.37 is due. As a result, the amount ordered is \$0.00.

PART VI: ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code, Sec. §413.031, the division has determined that the Requestor is entitled to \$0.00 reimbursement.

Authorized Signature

Medical Fee Dispute Resolution, Auditor

Date

PART VII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers' Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed \$2,000. If the total amount sought exceeds \$2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.